

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

63-039021

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 042 Primary Registration District No. 1000 Registrar's No. 1264

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

FILED NOV 4 1963

1. PLACE OF DEATH a. COUNTY Buchanan		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY Buchanan	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Joseph		c. CITY OR TOWN St. Joseph	
Length of stay in lb 45 years		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION D.O.A. Methodist Hosp.		d. STREET ADDRESS (If outside, give location) 1412 Ridenbaugh	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) OLIVER RALPH NEFF		4. DATE OF DEATH October 28 1963	
5. SEX male	6. COLOR OR RACE white	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 2/11/1896
9. AGE (last birthday) 67		10. IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) linotype operator		10b. KIND OF BUSINESS OR INDUSTRY Newspaper	
11. BIRTHPLACE (City and state or country) Nevada, Mo.		12. CITIZEN OF WHAT COUNTRY USA	
13a. FATHER'S NAME Oliver W. Neff		13b. MOTHER'S MAIDEN NAME Mae unknown	
14. NAME OF HUSBAND OR WIFE Flossie		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) yes W.W.#1	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Flossie Neff, St. Joseph, Mo.	
18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute, cardiac dilatation DUE TO (b) Calcific aortic stenosis DUE TO (c) Arteriosclerotic heart disease		INTERVAL BETWEEN ONSET AND DEATH Minutes Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from 10/22/56 to 6/26/63 and last saw him alive on 6/26/63		Death occurred at 12:05 a.m. on the date stated above, and to the best of my knowledge, from the causes stated.	
22a. SIGNATURE (Signature or type) Gary G. Folber, M.D.		22b. ADDRESS Suite 301 Physicians & Surgeons Bldg, St. Joseph, Mo.	
22c. DATE SIGNED Oct 28, 1963		23a. BURIAL, CREMATION, REBURY (State) 10/19/1963	
23b. DATE 10/19/1963		23c. NAME OF CEMETERY OR CREMATORY Memorial Park Cemetery	
23d. LOCATION (City, town, or county) St. Joseph Mo.		24. FUNERAL DIRECTOR Address	
25. DATE RECD. BY LOCAL REG. Nov. 1, 1963		26. REGISTRAR'S SIGNATURE Mrs. Clark Goodell	

USE BLACK INK
OR
TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

NOV 5 1963

Permit issued 10-28-63.
2117
2117
0108

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed William J. [Signature]

Licensed Embalmer No. 4535

P. O. Address St. Joseph, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).
If embalmed by a STUDENT, he also shall sign in his OWN handwriting.
If this body is not embalmed, fact should be so stated above.